FALCON CHIROPRACTIC CENTRE
health in motion

CONFIDENTIAL HEALTH QUESTIONNAIRE

CHILD INTAKE FORM File No. _____

Dear Parent,
It is our pleasure to welcome you to our clinic. Please complete the following questionnaire. Your answers will help us determine whether chiropractic care can help your child.
Thank you.

Name: Mast/Miss _____ D.O.B.: ____/____/____Age:_____
Surname Given Names (in full)

Parents Names: Father _____Mother _____

Guardians Name: _____

Postal Address: _____ Postcode _____

Email Address: _____

Telephone Numbers: Home _____ Mobile _____ Work _____

Other Siblings:

Name: Mast/Miss _____ D.O.B.: ____/____/____Age:_____

Mast/Miss _____ D.O.B.: ____/____/____Age:_____

Mast/Miss _____ D.O.B.: ____/____/____Age:_____

Mast/Miss _____ D.O.B.: ____/____/____Age:_____

How did you hear of the postural and spinal examination offered in this clinic?

☐ Web Page ☐ Doctor/Health Fund ☐ Sign ☐ Telephone

☐ Patient/Family/Friend – Name: _____

What concerns do you have regarding the health of your child?_____

_____

_____

** Please note that some of the questions may not be applicable to your child as this intake form covers ages from birth to 6 years.

BIRTH

The birth of your child can give vital clues as to potential spinal problems. Please answer the following questions very carefully.

Was your child delivered -

Normally	Yes/No	Breech	Yes/No	Posterior	Yes/No
Premature	Yes/No	At Term	Yes/No	Caesarean	Yes/No
Late	Yes/No	Forceps	Yes/No	Suction-Vacuum	Yes/No

Other _____

Birth weight _____ Apgar Scores _____ _____

How long were you in labour? _____ Hours How long did you "push" for? _____ Mins/Hours

Do you believe the birth was traumatic for your child? Yes/No

Was your child's head misshapen at birth? Yes/No

Were there any delivery complications? Yes/No

Details _____

_____

_____

_____

BIRTH TO SIX MONTHS

Was your child breast fed? Yes/No For how long? _____

Was your child formula fed? Yes/No For how long? _____Type _____

Did your child suffer with colic? Yes/No If yes, how bad was it? Mild Moderate Severe

Did your child suffer with reflux? Yes/No If yes, how bad was it? Mild Moderate Severe

Would you say your child was a:

Very poor sleeper Poor Sleeper Average Sleeper Good sleeper Very good sleeper

OTHER PROBLEMS

Please indicate by circling any of the following conditions which your child has experienced in the past:

Headache	Travel sickness	Poor co-ordination
Neck Pain	Seizures	Recurrent stomach aches
Constipation/Diarrhoea	Joint Pain	Scoliosis
Sinus Pain	Allergies	Convulsions
Bedwetting	Back Pain	Asthma
Growing Pains	Earaches/Infections	Night Terrors
Loss of appetite	Recurrent Tonsillitis	Chronic Colds
Visual disorders	Recurrent chest Infections	Hip Problems
Arm/leg Pain	Hyperactivity	Fever
Learning difficulties	Poor sleeping habits	Recurring Fevers
Digestive disorders	Constant fatigue	Other _____

MEDICAL HISTORY

How long did your child crawl for? _____ Months

Is your child accident prone? Yes/No Has your child had any significant falls? Yes/No

Please describe any falls or accidents your child has had. _____

_____

_____

Has your child ever been involved in a motor vehicle accident? Yes/No

Is your child on any medication? Yes/No

If yes please list _____

Has your child had any diseased/illnesses? Yes/No

If yes please list _____

Vaccination History? _____

Has your child ever been hospitalised or had surgery? Yes/No

If yes, please describe: _____

_____

_____

Has your child ever had broken bones or sprain injuries? Yes/No

If yes, please describe: _____

_____

_____

Has your child ever been assessed for scoliosis? Yes/No

Has your child a learning disorder? Yes/No

_____

How many times has your child taken antibiotics?

In the last six months _____ During Lifetime _____

How many doses of other Prescription Medication has your child taken?

In the last six months_____ During Lifetime _____

PREVIOUS CHIROPRACTIC CARE

Has your child had previous chiropractic care? Yes/No If yes, reason for care _____

_____

Name of Chiropractor _____ Date of last treatment_____

Were x-rays taken? Yes/No

Do you give permission for a copy of your child's medical information to be obtained from your Doctor or previous Chiropractor should this be necessary? Yes/No

DECLARATION

I hereby declare that the information supplied is correct to the best of my knowledge.

Parents/Guardian Signature _____ Date _____